CHAPTER I - OVERVIEW AND ADMINISTRATION

1.01 Long Term Support in Wisconsin

The Medicaid Home and Community Based Waiver (HCBW) programs were authorized by Congress in 1981, and began in Wisconsin in 1983 with the Community Integration Program. The Medicaid waivers represented a significant step, taken to mitigate the Medicaid program's institutional bias that had led to the extensive development and utilization of nursing homes and Intermediate Care Facilities for the Mentally Retarded (ICF-MR), also called Facilities for the Developmentally Disabled (FDD). Recognizing the problem, Wisconsin had taken its own steps to reverse the trend toward institutionalization with the creation of the Community Options Program (COP).

Created in 1981, COP was developed to provide eligible persons a safe community alternative to institutional placement. In addition, COP was designed to bring a system of care management and service coordination to the complex world of community services while placing the consumer in the center of the service planning process. The program intent is to forge a working partnership between the participant and the care manager/ support and service coordinator (CM/SSC), in which they jointly develop a plan that addresses the participant's identified needs and meets her/his desired individual outcomes. While keeping the participant's preferences in mind, the care manager or support and service coordinator, participant and other team members seek the most cost-effective means to meet those individual outcomes in a integrated community setting.

The Medicaid waiver programs are built upon a foundation of primary program values. These values support individual choice, the enhancement of relationships, the building of accessible, flexible service systems, the achievement of optimum physical and mental health for the participant, and the promotion of presence, participation and optimal social functioning in the community. The program values further seek to ensure that participants are treated with respect and assure that service systems empower the individual, build on their strengths, enhance individual self worth and supply the tools necessary to achieve maximum independence and community participation.

The Medicaid waiver programs covered in this manual include:

- Brain Injury Waiver (BIW)
- Children's Long Term Support Waivers (CLTS)
- Community Integration Program 1A Waiver (CIP 1A)
- Community Integration Program 1B Waiver (CIP 1B)
- Community Integration Program II Waiver (CIP II)
- Community Options Program Waiver (COP-W)

There are several other community waiver programs that serve similar populations that are not addressed by this manual. These include the Family Care Program and the PACE/Partnership projects.

Policies described in this manual are grounded in Chapter 46 Wisconsin Statutes, and DHFS administrative rules and in provisions contained in the waiver applications submitted to and approved by the federal Centers for Medicare and Medicaid Services (CMS). Policies regarding the local administration of the community waivers programs must be specified in the county's COP Plan.

Exceptions to any requirement in this manual may be granted unless federal or state law or Wisconsin administrative code governs the requirement. County staff or their designated agents must request any exception in writing in a format prescribed by the appropriate waiver management section within the Bureau.

1.02 Reserved

1.03 The Medicaid Waiver Mandate

By statute (46.27(6r)(a), regular COP funds may not be used for long-term support services that may be funded under one of the Medicaid Home and Community Based Waiver programs. The waiver mandate is intended to increase the total resources available to serve participants while maximizing the use of federal funds to support the provision of community-based services. Waiver funds must be used when:

- The participant is eligible or becomes eligible for the waiver; and
- The agency has Medicaid waiver resources available; and
- The services to be provided are covered by the waiver.

A. Eligibility

The waiver agency must seek Medicaid waiver funding unless the applicant is found to be ineligible for the Medicaid community waivers. The mandate **does not apply** when:

1. The person does not meet Medicaid waiver level of care eligibility requirements; or,
2. The person does not meet Medicaid financial eligibility requirements; or,
3. The person does not meet Medicaid waiver program non financial eligibility requirements, including residency status, etc.; or,
4. The person does not meet the Medicaid waiver target group criteria; or,

5. The person's preferred living arrangement is appropriate to meet his/her needs but is not an allowable living arrangement under the applicable Medicaid waiver (see Chapter II of this manual).

B. Availability

Medicaid waiver resources are considered available if:

1. The agency has unused CIP 1A, CIP 1B (state-matched) or CIP II slot that can be designated for a locally matched slot in CIP 1B or BIW or CLTS or,

2. The agency has unused COP-Waiver match allocated by the state that is not fully committed to current participants.

3. The agency has unused state funds (COP, Community Aids or other funds) allocated by the state that are not expended. While not a specific obligation of the waiver agency, a child participating in the Family Support Program (FSP) who is also eligible for the waiver should have those FSP funds match federal funds under the appropriate waiver.

1.04 Exemptions from the Waiver Mandate

While the mandate does not apply where Medicaid waiver eligibility cannot be established, there are also exemptions to the waiver mandate. Persons exempt from the waiver mandate include:

1. Any person for whom a Medicaid waiver application is being processed is exempt for up to 90 days, provided that within the first ten days after services are initiated:
   a. A referral is made to Economic Support for a Medicaid application (unless the person is already receiving Medicaid); and,
   b. Waiver program functional eligibility is established; and,
   c. An initial individual service plan is completed.

2. Any person whose total state share of costs under COP would be less than the state share of costs under the Medicaid community waiver. Documentation of this exception must be placed in the participant's record.

3. Any person whose total cost of care for COP-funded services is less than $100 per month may be exempted with no cost-effectiveness documentation required.

4. Any person who will receive services (other than care management/support and service coordination (CM/SSC) or equipment that are not allowed by the waivers.

5. Any single parent of minor children whose income places them in category C, (medically needy) using the Medicaid community waiver cost sharing worksheet (DDE-919) or CARES.

6. Persons who meet the hardship criteria and are exempt from participation in the Medicaid Purchase Plan (MAPP).

Note: Any person exempt from the waiver mandate may still apply for Medicaid state plan (Medicaid card) services.

1.05 Registering Applicants on HSRS

County agencies are required to register on the Human Services Reporting System (HSRS) applicants of any age who, based on a preliminary review of functional and financial eligibility, are likely to meet the criteria for COP or Medicaid waivers participation but who are not yet receiving funding. The purpose of using HSRS to register these applicants is to build a statewide registry containing standardized information that may be used to do effective program planning. Persons to be entered on this HSRS applicant registry include those who are:

- Currently in an institution and who request COP or Medicaid waivers services; or,
- Currently receiving no publicly funded community long-term care services; or,
- Currently receiving some publicly funded community long-term care services, but not from COP or a Medicaid waiver.

Note: Participants who are already receiving COP or Medicaid waiver funded services are not to be placed on this registry.

1.06 County Waiting Lists

A. Creating County Waiting Lists

Subject to the policy described in the COP Guidelines and Section 1.06 of this manual below, counties may keep local applicant data to satisfy their local policies and program management requirements.

1. Waiting Lists for Assessments and Individual Service Plans:

   The only permissible circumstances in which a waiting list for assessments and individual service plans may be established is when the agency has expended all funds available for assessments and care plans. Any applicant denied an assessment or an individual service plan for this reason **must** be provided the opportunity to be placed on a waiting list for assessment or individual service plan development.

2. Waiting Lists for Services:

   The only permissible circumstances in which a waiting list for services may be established are when the county agency has:

   a. Determined that the cost of providing the community services identified in the assessment will cause the agency to exceed local, state and federal funds available (service funds are available if they have not yet been expended or committed to current participants); or,

   b. Determined that the cost of meeting the support and service needs identified in the assessment will cause the agency to exceed the allowable average COP costs for all COP participants and the Department has denied a variance to the allowable average service cost; or,

   c. Determined that serving the applicant will prevent the agency from meeting significant proportions requirements; or,

   d. Determined that the cost of meeting the support and service needs identified in the assessment will cause the agency to exceed a locally established limit on service expenditures.

   Note: Any eligible applicant or current participant who is denied services for the reasons described above must be provided the opportunity to be placed on a waiting list for services and registered on HSRS (See Section 1.05).

B. Procedures for Placing Persons on County Waiting Lists (refer to previous Section 1.05 as appropriate)

The following procedures must be used when placing persons on the local waiting list for services:

1. The agency shall make a preliminary determination of financial and functional eligibility as well as the need for long term care services.

2. The agency shall document the contact with the person or other referral source and the date of placement on the waiting list.

3. The agency shall make an offer of an assessment which, if accepted, must be completed within 45 days. If the applicant agrees, the assessment may be delayed until a time nearer to when funds for Medicaid community waiver services will become available.

4. The agency shall update the waiting list every six months and provide each applicant/participant placed on the waiting list with a notification of her/his status on the waiting list as well as an estimate of when funding for services may become available.

5. The agency shall ensure that participants from another county who move into the county are placed on the local waiting list for services while funding for their service plan from their county of origin continues. (See Chapter II-Section 2.08).

C. Procedures for Serving Persons from County Waiting Lists

The county waiver agency must have a comprehensive, written policy for serving persons from locally created waiting lists. The county policy must be incorporated into the county's Community Options Plan. The policy must include the following standards:

1. The policy for serving persons from the waiting lists must be fair and equitable, and ensure movement of persons on the list(s) at a reasonable pace.

2. The policy must ensure that persons are served in the order that they are placed on the waiting lists. A consistent, reasonable effort must be made to serve persons on this basis and must not allow for the continual passing over of persons on the list(s) based on the level of funding needed.

    a. A reasonable effort to serve higher cost persons may include the provision of services based on partial funding availability.
    b. When full funding is not available the agency may provide for less than all of the assessed services identified but the services provided must assure the health and safety of the participant.
    c. The agency shall fully inform the participant of any risk inherent in the implementation of the partially funded plan and may not proceed with service delivery without the informed consent of the participant.
    d. Once partial services are established and health and safety are assured, the remaining identified services must be added as funding becomes available.

3. The decision to increase levels of service or to provide additional services to a participant must be based on a documented, assessed need. Priority must be given to those services that address participant health and safety.

4. Counties may establish additional, local waiting list priorities that target specific persons or groups, meet the needs of persons in crisis or respond to other locally defined circumstances.

The county waiting list policy or policies must be approved by the County Long Term Support Planning Committee and included in the county Community Options Plan.